

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=63-019130**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

628

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

**FILED JUN 3 1963**

1. PLACE OF DEATH

a. COUNTY Buchanan

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN St. Joseph,

Length of stay in 1b  
Life

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION St. Joseph's Hospital

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Buchanan

c. CITY OR TOWN St. Joseph,

Inside Limits  
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)  
1815 North 31st Street

Reside on Farm  
Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)

First Middle Last  
MILDRED E. DAWSON

4. DATE OF DEATH Month Day Year  
May 22, 1963

5. SEX

Female

6. COLOR OR RACE  
White

7. Married ☒ Never Married ☐  
Widowed ☐ Divorced ☐

8. DATE OF BIRTH  
Feb. 23, 1906

9. AGE (last birthday)  
57

IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10b. KIND OF BUSINESS OR INDUSTRY  
Own Home

11. BIRTHPLACE (City and state or country)  
St. Joseph, Missouri

12. CITIZEN OF WHAT COUNTRY  
U.S.A.

13a. FATHER'S NAME

Charles Lanning

13b. MOTHER'S MAIDEN NAME

Minette Stanford

14. NAME OF HUSBAND OR WIFE

Clyde Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
No

17. INFORMANT

Mr. Clyde Dawson-St. Joseph, Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Ventricular fibrillation*

INTERVAL BETWEEN ONSET AND DEATH  
*The victim*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

*Myeloma heart disease*

*4-6 months*

DUE TO (c)

*Multiple myeloma*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
*Controlled myeloma. (Do not believe controlled to her death.)*

PART III. If deceased was female was there a pregnancy in last 90 days.  
☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

*1*

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from *11-23-62* to *5-22-63* and last saw her alive on *5-22-63*  
Death occurred at *12:15 PM* on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE

*Lucie N. Id. M.D.*

22b. ADDRESS

*902 Edward St. Joseph, Mo.*

22c. DATE SIGNED

*5-23-63*

23a. FUNERAL, CREMATION, REMOVAL (Specify)

23b. DATE

*May 24, 1963*

23c. NAME OF CEMETERY OR CREMATORY

*Ashland Cemetery*

23d. LOCATION (City, town, or county) (State)

*St. Joseph, Missouri*

24. FUNERAL DIRECTOR

ADDRESS

*Meierhoffer-Fleeman Inc., St. Joseph, Mo.*

25. DATE RECD. BY LOCAL REG.

*May 27, 1963*

26. REGISTRAR'S SIGNATURE

*Mrs. Clark Goodell*

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION  
*L.W. Ide, H.M.*

RECEIVED

FILED  
27112

1  
1  
0  
2

Original sent to State Board of Health

**STATEMENT BY LICENSED EMBALMER**

0-3

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4679

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.